



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Martin R. Hullender, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-3893-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 31, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... this request was in response to a \$350.00 reduction of the \$865.00 for the DDE performed on 8-8-14. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed \$350.00 for code 99456-W5/WP yet the DWC69 indicates the claimant is not at MMI. Thus code 99456-W5/WP is not appropriate coding."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2014	Designated Doctor Examination	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.

- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code CAC-4 – "THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING," and 732 – "ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED."

28 Texas Administrative Code §134.204 (j)(4) states, in relevant part, "The following applies for billing and reimbursement of an IR evaluation...(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.'"

This dispute involves CPT code 99456-W5-WP, which indicates that the provider performed an evaluation to determine if the injured employee has reached maximum medical improvement (MMI) and assign an impairment rating (IR), including both the professional and technical components of performed testing to help determine the impairment. Review of the submitted information finds that the narrative and Report of Medical Evaluation (DWC069) indicate that the injured employee had not reached MMI, so no IR was assigned. For this reason, modifier "WP" was improperly included. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	<u>Laurie Garnes</u> Medical Fee Dispute Resolution Officer	<u>September 24, 2015</u> Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.